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Combined Meeting of The Blueprint Executive Committee and Blueprint Planning and Evaluation Committee

July 19, 2017

Attendees: M. Dugan; C. Elmquist; P. Farnham; A. French; C. Fulton; C. Gustafson; L. Hendry; P. Jackson; K. Lange; J. Le; M. McAdoo; E. McKenna; C. Perpall; J. Plavin; J. Samuelson; B. Tanzman; T. Tremblay; N. Walke; M. Young

By phone: B. Bick; P. Biron; S. Bruce; A. Buchanan; F. Clark; P. Clark; T. Coates; J. Evans; J. Fels; K. Hein; J. Hester; P. Jones; H. Klein; P. Launer; M. Lawrence; R. Lawson; S. Narkewicz; J. Peterson; J. Plavin; J.Riffon; L. Ruggles

The meeting opened at 8:30 a.m.

I. Opening Remarks and Announcements: Beth Tanzman

- Today's agenda and PowerPoint slide deck were distributed prior to this meeting.
- B. Tanzman stated at today's meeting, we will discuss the Medicare PCMH, CHT and SASH payments for CY 2018, start the discussion on the NCQA 2017 PCMH recognition process, review key findings from the final evaluation of the Medicare Advanced Primary Care Practice Demonstration (MAPCP) and program updates.

II. Medicare PCMH, CHT and SASH Payments CY 2018

- B. Tanzman reviewed *slide #3, Budgeting 2018 Program Targets (from OneCare's presentation to the Green Mountain Care Board, GMCB, on July 13,2017).*
- Medicare's participation will need to flow through the ACO and be part of the all-inclusive population-based payment. The payment arrangement is between OneCare and CMS.
- B. Tanzman reviewed *slide #4, PHM/Payment Reform Program Investments (from OneCare's presentation to the Green Mountain Care Board, GMCB, on July 13,2017).*
- M. Dugan questioned whether the stated amounts are enough for the SASH panel. B. Tanzman also stated that new practices onboarded as a PCMH will affect the payments.

- E. McKenna questioned who will be sending out the payments. B. Tanzman responded for the risk communities, it may come from OneCare. The details have not been worked out yet.
- P. Farnham questioned if OneCare will be administering the Medication Assisted Treatment (MAT) payments. B. Tanzman responded that initial conversations with OneCare indicate they are not interested in assuming management for the MAT payments. MAT payments will still be administered with Blueprint/Department of Vermont Health Access (DVHA) for the foreseeable future.
- There is tremendous interest from the Federal government regarding the Hub & Spoke model. Richard Baum, White House Drug Czar, and Dr. Stephen Cha and other team members from the Center for Medicare and Medicaid Innovation (CMMI), all visited Vermont on separate occasions last week. Both were impressed with the Vermont model and have discussed packaging this as a national model.
- R. Lawson, Yoga Therapist, stated the plan seems to be more focused on data and payment rather than services. B. Tanzman thanked R. Lawson for her comments.

III. Initial Findings from NCQA 2017 PCMH Recognition Process

- B. Tanzman reviewed *slide #6 and slide #7, 2017 NCQA PCMH Process*, and offered that the Vermont statute is specific about payment as contingent on the NCQA process. That said, NCQA is revising the process and we want to assess the role in improving care and decreasing administration burden. We created a small group who met with NCQA and spent time understanding the process and attempting to assess impact of the changes.
- Overall, there are very few changes in the 2014 clinical standards compared to the 2017 standards. The submission process is very different for recognition now include two stages – sustaining and engaging. It's hard to be definitive but we anticipate 50% reduction in paperwork.
- B. Tanzman stated NCQA has been responsive to what they heard on the ground. J. Plavin mentioned it's not really a bad thing for the measures to stay stable this year. J. Plavin questioned if they ever thought of accrediting the State.
- B. Bick questioned if the specialty recognition will be affected. J. Samuelson responded NCQA did not change or touch the recognition process for specialty but are reviewing for 2018. It is in the public commentary phase right now.
- B. Tanzman thanked K. Whitcomb, from BCBS, for her participation. Also, many thanks to Julie Riffon for her crosswalk of the old and new process.
- Blueprint consulted with the Committee to extend CHT payments to practices when they officially "engage" the NCQA process. The 2017 standards will require all practices to obtain the equivalent of a Level 3 in the 2014 standards. The recognition process for new practices will start 1 year from their anticipated recognition date. Blueprint recommended we establish practices as PCMHs at the start of the recognition process rather than having frontloading turn on at the start of the process.

IV. Final Evaluation of the Medicare Advanced Primary Care Practice Demonstration (MAPCP)

- B. Tanzman reviewed *slide #9, CMS Multi-Payer Advanced Primary Care Practice Demonstration, Highlights from the Final Report,* and stated this evaluation reports the

performance and demonstration in the seven (7) other participating States and in Vermont. From the national point of view, it is cost neutral with no impact on health outcomes.

- Vermont demonstrated greatest cost savings: the evaluation defined "successful" states as those that generated net savings for Medicare, relative to both their PCMH and non-PCMH comparison groups. By this definition, Vermont was by far the most successful state, generating $3.17 in savings for every $1.00 of demonstration fees paid. Three other states were also deemed successful, generating from $1.41 to $2.16 savings per $1.00 of demonstration fees.
- Care managers were viewed as the "most central, transformation aspect of the PCMH model." In most participating states, care managers provided follow-up after hospitalization, self-management education, medication reconciliation, connection to community-based services, and development of individual care plans. Note that in Vermont these functions were spread out across PCMH staff and Community Health staff with a range of titles (not only official "Care Managers").
- Other new resources essential to successful initiatives were "shared support teams" (i.e. Community Health Teams) and technical assistance to practices.
- L. Ruggles stated this is consistent with other research being done around PCMH. PCMH by itself is not as effective without CHT and care coordinators.
- J. Peterson shared VNA's effort around ER utilization. VNA is having monthly meetings with the ER staff to discuss discharge, follow ups and education with patients. B. Tanzman thanked J. Peterson for sharing her efforts.

V. Program Updates

- The committee discussed the data on *slide #16 and slide #17, Changes to Data and Methods (both from Onpoint HealthData).* B. Tanzman and P. Jones thanked BCBS in working with the State on the GAT data.

With no further time, the meeting adjourned at 10:06 am.

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Executive Committee

Planning & Evaluation Committee

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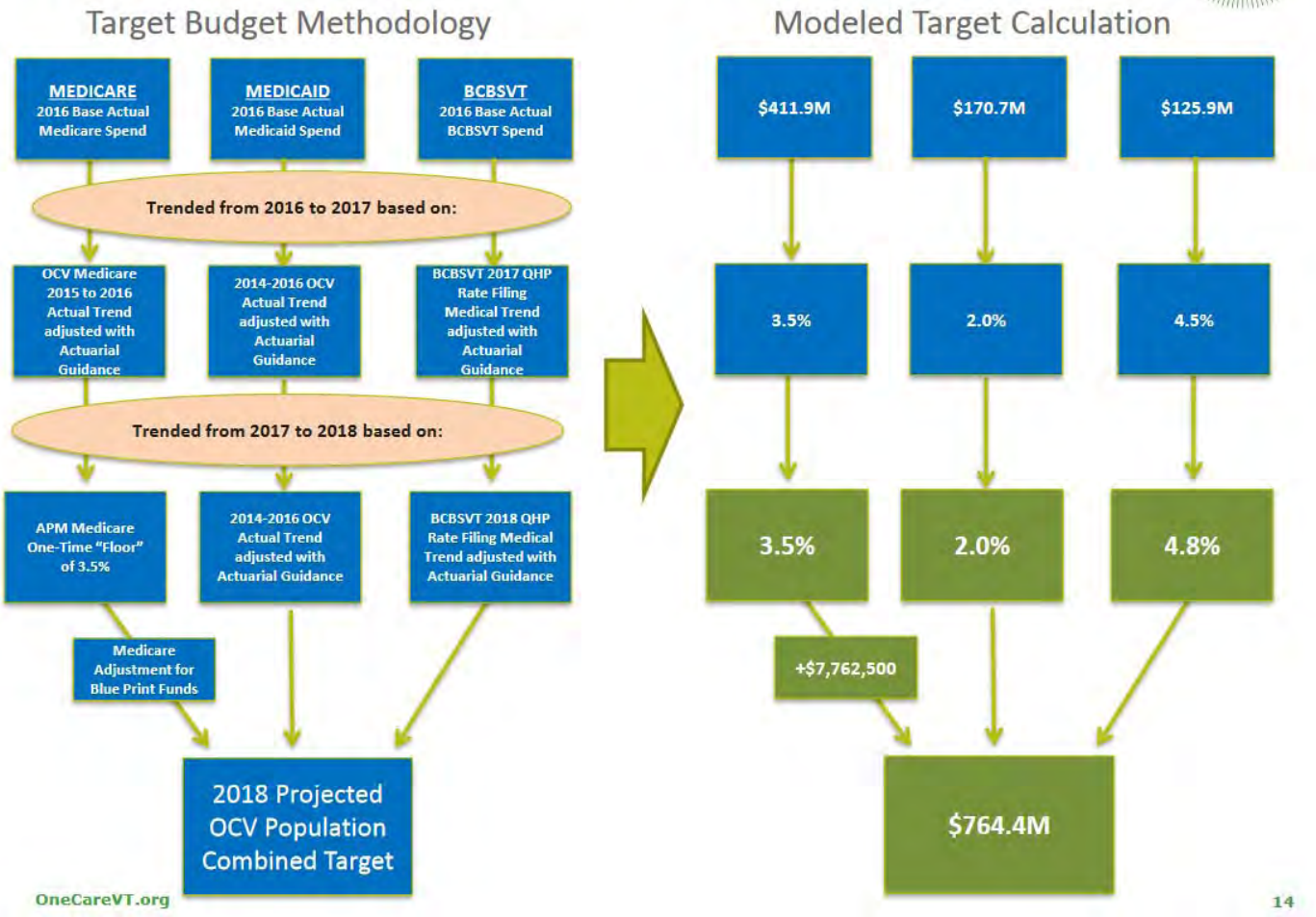
Budgeting 2018 Program Targets



PHM/Payment Reform Program Investments

Program	2018 Investment	
Basic OCV PMPM for Attributing Providers	$ 5,348,694	Supporting Primary Care and Community-Focused Elements of PHM Approach
Complex Care Coordination Program	$ 7,580,109	
RiseVT Program	$ 1,200,000	
CHT Funding Risk Communities	$ 1,746,360	Supporting Blueprint for Health Continuity and Ongoing Collaboration with ACO Model
CHT Funding Non-Risk Communities	$ 772,538	
SASH Funding Risk Communities	$ 2,417,942	
SASH Funding Non-Risk Communities	$ 852,012	
PCP Payments Risk Communities	$ 1,319,336	
PCP Payments Non-Risk Communities	$ 654,313	
Value-Based Incentive Fund	$ 5,559,260	Rewarding High Quality
PCP Comprehensive Payment Reform Pilot	$ 1,800,000	Supporting True Innovation in Independent PCP Practices
Total	$ 29,250,563	

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2017 NCQA PCMH Process

NCQA updated the PCMH submission process to reduce administrative burden

- Clinical standards had few changes
- Submission process has two stages (sustaining and engaging)
- No levels or scores
- Paperless

Small group assessment: Process seems to be significant reduction of administrative burden

2017 NCQA PCMH Process

- Engaging – practices work to achieve the majority of the clinical elements
  - Regular web-based check-ins until practice achieves "sustaining"
  - Practices recognized as Levels 1-2 on 2014 standards "Engaging Process" est. 6 month timeline to "Sustaining"
  - Practices with no PCMH recognition go through "Engaging Process" est. 12 months to recognition

- Sustaining – annual check-in "sustaining"
  - attest to maintaining clinical care
  - on-line audit (no paper/binder documentation) for 6 elements
  - Practices recognized as Level 3 on 2014 standards move to "Sustaining Process"

- Recommend starting PCMH PMPM and CHT payments when a practice enters engaging

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CMS Multi-Payer Advanced Primary Care Practice Demonstration

Highlights from the Final Report

- 8 state test of Patient Centered Medical Home (PCMH) initiatives running July 2011 – December 2016
- National findings: cost neutral, no consistent impact on outcomes
- State success defined as net savings for Medicare, relative to both PCMH and non-PCMH comparison groups: Vermont by far the most successful state, generating $3.17 in savings for every $1.00 of demonstration fees
- No corresponding reduction in Medicaid spending in Vermont – only budget neutral

https://downloads.cms.gov/files/cmmi/mapcp-finalevalrpt.pdf

National Lessons, Success Factors

National demonstration lessons:

- Transformation is possible
- Participation of all payers and alignment of payments is critical
- It takes time to see the results of practice transformation

Success factors for PCMH initiatives across states:

- Successful initiatives incentivized consistent activities across payers
- Successful initiatives provided performance bonuses to practices

The most valuable new resources are Care Manager functions, Community Health Teams, and technical assistance or practice coaching.

Vermont Expenditures and Utilization Through 2014

- Note statistically significant:
  - Reduction in Medicare spending
  - Reduction in outpatient spending vs. PCMH comparison group (CG)
  - Increase in admissions for potentially avoidable conditions vs. non-PCMH CG
  - Increase in ER visits not leading to hospitalization
  - Decrease in medical specialist visits vs. non-PCMH CG

Table ES-5
Changes associated with the MAPCP Demonstration as of December 31, 2014: Vermont

Outcome		Vs. PCMH CG	Vs. non-PCMH CG
Medicare savings			
Total gross savings	Total	$82,271,080*	$61,754,919*
Net savings	Total	$63,930,154*	$43,413,993
Expenditures			
Total Medicare expenditures	Total	−$82,271,080*	−$61,754,919*
	PBPM	−$36.06*	−$27.07*
Acute-care expenditures	Total	−$21,444,041	−$13,870,188
	PBPM	−$9.40	−$6.08
Outpatient expenditures	Total	$18,250,248*	$5,543,513
	PBPM	$8.00*	$2.43
Total Medicare expenditures for beneficiaries with multiple chronic conditions	Total	−$16,984,150	$1,165,904
	PBPM	−$34.77	$2.39
Utilization			
All-cause admissions	Total	−441	874
	Rate	−0.58	1.15
Admissions for potentially avoidable conditions	Total	692	1,179*
	Rate	0.91	1.55*
30-day unplanned readmissions	Total	−646	−26
	Rate	−20.10	−0.80
ER visits not leading to hospitalization	Total	11,140*	8,091*
	Rate	14.65*	10.64*
Primary care visits	Total	−5,794	−20,417
	Rate	−7.62	−26.85
Medical specialist visits	Total	−11,041	−44,280*
	Rate	−14.52	−58.23*

NOTES:

- Utilization rates (except readmissions) are per 1,000 beneficiary quarters. Readmission rates are per 1,000 beneficiary quarters with a live discharge.
- Total MAPCP Demonstration fees were $18,340,927. Thus, for each dollar spent on MAPCP Demonstration fees in Vermont, there was a savings of $4.49 in Medicare expenditures compared with PCMH comparison practices and a savings of $3.37 in Medicare expenditures compared with non-PCMH comparison practices.

CG = comparison group; ER = emergency room; MAPCP = Multi-Payer Advanced Primary Care Practice; PBPM = per beneficiary per month; PCMH = patient-centered medical home.

* Statistically significant at the 10 percent level.

SOURCE: Medicare claims from 2006 to 2014.

Vermont Demonstration Successes

- Well-established initiative, foundation for other reforms
- Implemented care management through well-integrated CHTS and SASH: "the most visible and beneficial aspect of the demonstration"
- Overall Medicare savings driven by lower expenditures on post-acute-care and specialty physicians, laboratory and imaging services (but no similar reductions in Medicaid beneficiaries)
- Better continuity of care for Medicare beneficiaries

Vermont Demonstration Opportunities

- Insufficient improvement in primary care access, plus more urgent care facilities = more ED use. Need 24-7 primary care provider availability.
- Little care process improvement for diabetes, asthma (but increase in appropriate use of antidepressant meds for adult Medicaid beneficiaries)
- Not enough mental health professionals, but increased focus and Hub & Spoke may be helping people in need get help for the first time – temporarily increasing expenditures
- Lack of functioning health IT platform to support practices, CHTs, SASH teams in accessing reliable data to manage their patients
- Must continue to evolve payment methodology (and amounts) over time to maintain effectiveness

Implementation Issues

1. Health IT: struggle to obtain reliable data to manage populations
2. Commercial payers frustrated by lack of information about CHT interactions with plan beneficiaries
3. End of year 3 BP payments insufficient to support PCMH & CHT infrastructure

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Changes to Data and Methods

RY16 Profiles Compared to CY15 Profiles

Demographic Snapshot - RY16 Compared to CY15					
		CY15	RY16	Difference	% Diff
Adult	Average Members	258,837	241,613	-17,224	-7%
	Medicaid	53,763	70,613	16,850	24%
	Medicare	70,171	60,293	-9,878	-16%
	Commercial	134,903	110,706	-24,197	-22%
		CY15	RY16	Difference	% Diff
Pediatric	Average Members	75,161	70,813	-4,348	-6%
	Medicaid	42,962	45,791	2,829	6%
	Medicare	0	0	0	0%
	Commercial	32,199	25,022	-7,177	-29%
Grand Total		CY15	RY16	Difference	% Diff
Adult & Pediatric	Average Members	333,998	312,426	-21,572	-7%
	Medicaid	96,725	116,404	19,679	17%
	Medicare	70,171	60,293	-9,878	-16%
	Commercial	167,102	135,728	-31,374	-23%

Changes to Data and Methods
RY16 Profiles Compared to CY15 Profiles

Gobeille Decision

- Supreme Court decision – March 1, 2016 – held that the Employee Retirement Income Security Act (ERISA) pre-emps Vermont's statute as applied to ERISA plans.
- Most payers stopped submitting ERISA data in April 2016. This resulted in a decline of approximately 35% of commercial members
- Preliminary Onpoint analysis indicates that drop in VHCURES' counts due to Gobeille can be mostly attributed to the following payers:
  - BCBSVT (50%)
  - CIGNA (42%)
  - The Vermont Health Plan (8%)
- BCBSVT has worked with their ERISA groups, and will be submitting ERISA data for approximately 75% of their ERISA groups at the end of July 2017. The data will be retro to April 2016.